DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Bk-1-033

State File No. 15678

FILED MAY 5 1944

Registration District No. 5184 Primary Registration District No. 3059 & 95 Registrar's No.

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Farmington Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No. 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution One mo (Specify whether years, months or days)
In this community 21 days

2. USUAL RESIDENCE OF DECEASED: 94
(a) State Mo. (b) County
(c) City or town St. Louis, Mo. (If outside city or town limits, write "RURAL")
(d) Street No. Biltmore Hotel (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Moses Woods Hoge

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male | 5. Color or race White | 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased May (Month) 18 (Day) 1861 (Year)

8. AGE: Years 82 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace Cooper Co. (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Physician

11. Industry or business "

FATHER
12. Name John James Hoge
13. Birthplace Columbus, Ohio (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Calhoun
15. Birthplace Jamestown, Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records
(b) Address State Hospital No. 4

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof May 5 1944 (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director Miller Funeral Home
(b) Address Farmington, Mo.

19. (a) 5-5-44 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month May day 5 year 1944 hour 9 minute 15 M.

21. I hereby certify that I attended the deceased from March 1st, 1944, to May 5, 1944, that I last saw h. alive on May 5, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Arteriosclerosis, Generalized & Marked	2 yrs.
Due to:	
Due to:	
Other conditions: Senile Psychosis (Include pregnancy within 3 months of death)	2 yrs

Major findings:
Of operations 97
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Garnett L. Doss (M.D. or other)
Address Farmington Date signed 5/5/44

1323

(Licensed Embalmer's Statement on Reverse Side)

Mo.

RECEIVED 5-13-44

District Health Officer No. 4

District File Number 544-386

Date Filed 5-13-44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~ .....

....., Registered Apprentice No. .....

working under my personal supervision.

Signed Burl J. Miller

Licensed Embalmer No. 3752

P. O. Address Farmington, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 316 Primary Registration District No. (6075) Registrar's No.

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Farmington Rural St Francois
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hosp # 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Moses W. Hoge
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Nov 18 (Month) (Day) 8 (Year)

8. AGE: Years 82 | Months 5 | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) Mo. (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director Forrest Johnson
(b) Address

19. (a) (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day year 1946 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

156078